UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
DIVISION OF JUDGES

NORTON HEALTH CARE, INC. d/b/a
NORTON AUDUBON HOSPITAL AND
NORTON SUBURBAN HOSPITAL, SUCCESSOR
TO AUDUBON REGIONAL MEDICAL CENTER

and

Cases 9-CA-31725
9-CA-32276
9-CA-33632
9-CA-33565-1, -2, -3, -4

NURSES' PROFESSIONAL ORGANIZATION,
AFFILIATED WITH UNITED NURSES OF AMERICA,
AMERICAN FEDERATION OF STATE, COUNTY
AND MUNICIPAL EMPLOYEES, AFL-CIO

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SUPPLEMENTAL DECISION AND ORDER

Statement of the Case

IRA SANDRON, Administrative Law Judge. This matter arises out of a second amended compliance specification and notice of hearing issued by the General Counsel on June 25, 2002, relating to the Board's Decision, Order, and Direction of Second Election in 331 NLRB 374 (the Order),[1] issued on June 22, 2000.

The Respondent assumed ownership of Audubon Hospital (Audubon) and Suburban Hospital (Suburban), effective September 1, 1998. The Order related to the election held at Audubon on March 3 and 4, 1994, and unfair labor practices (ULPs) committed there in the years 1994 to 1996, when Columbia/HCA Healthcare Corporation d/b/a Audubon Regional Medical Center (Columbia) owned and operated both hospitals. The Respondent's status as a successor employer to Columbia has not been contested.

In its Order, the Board affirmed Judge John West's findings that Columbia had committed numerous violations of the Act at Audubon. It ordered Columbia and its successors, to, inter alia, offer Registered Nurses (RNs) Patricia Clark and Martha Ann Hurst patient care leader positions (to which they were denied promotion in mid-January 1996), reinstate RN JoAnn Sandusky to her former position as a lactation consultant (she was "laid off" or

[1] GC Exh. 1(a). All dates are in 2000 unless otherwise indicated.

terminated on August 9, 1994), and make whole all three employees for their losses resulting from ULPs committed against them because of their activities on behalf of the Charging Party/Union.[2] The Board also agreed with the judge that Columbia's unlawful conduct had interfered with the election, and it directed that a second election be conducted. In light of Columbia's numerous ULPs, the Board further directed, inter alia, that the Respondent furnish the Union, upon request within 1 year of the date of the Order, with the names and addresses of unit employees.

The General Counsel contends that the Respondent has failed to comply with these provisions of the Order. The Respondent denies any noncompliance, contending that it made valid offers to Clark, Hurst, and Sandusky in July 2000, that the position of patient care leader (retitled charge nurse and then clinical coordinator)[3] was and is supervisory, and that it was under no obligation after 1 year from the date of the Board's Order to furnish the Union with the names and addresses of unit employees.

Backpay and pension contributions for Clark, Hurst, and Sandusky for the period through July 12, 2000, were resolved with Columbia. Therefore, the backpay specifications before me are limited to the period from the third calendar quarter of 2000 through the first quarter of 2002. Further, without conceding liability, the Respondent's counsel stipulated to the accuracy of the gross backpay, interim earnings, and pension contribution amounts owed to Clark, Hurst, and Sandusky for said period, as contained in General Counsel's Exhibits two through four.

Pursuant to notice, a trial was held before me in Louisville, Kentucky, on October 21, 22, and 23, 2002, at which the General Counsel and the Respondent were represented by counsel, and the Union was represented by its director of organization, Kay Tillow. All parties were afforded full opportunity to be heard, to examine and cross-examine witnesses, and to introduce evidence. The General Counsel, the Respondent, and the Union filed posthearing briefs, which I have duly considered.

Upon the entire record in this case, including my observations of the witnesses and their demeanor, I make the following

Findings of Fact

Witnesses for the General Counsel included the following: Clark, Hurst, Sandusky, and Tillow; supervisory field examiner Matthew Denholm; and, under Section 611(c), Judy Kees, Norton's division director of human resources management (HR) for all of Norton's hospitals since February 2002, previously HR director of Audubon since July 1999. The Respondent's witnesses included Kees; Christopher Brown, clinical manger of a med/surg unit; Randa Bryan, manager of the emergency room (ER); Ladonna Thomas, manager of the open heart unit; Charlotte Ipsan, clinical manger of the neo-natal intensive care unit (NICU) at Suburban; Laurie

[2] All compliance matters related to a fourth employee named in the Order, Terry Hundley, were resolved prior to the hearing (see GC posthearing br. at p. 3).

[3] In 1996, the position was called patient care leader. By July 2000, it had been renamed charge nurse, and by the time of the hearing in the instant matter, it had undergone yet another name change, to clinical coordinator. Witnesses for both the General Counsel and the Respondent used the terms interchangeably, and none of the parties contend that the status of the position, however entitled, has changed since 1996 in terms of being supervisory or nonsupervisory. Therefore, for ease of reference, I will hereinafter generally use the current designation of clinical coordinator.

Shawn, staff nurse in NICU at Suburban; and Mary Gruebbel, vice-president for patient care services. Clark was recalled as a rebuttal witness by the General Counsel.

Background

Audubon and Suburban are among the seven hospitals the Respondent currently owns and operates in the Louisville, Kentucky area. Audubon employs about 1,400 employees, including 350 staff RNs or staff nurses, 30 - 40 clinical coordinators, and 20 clinical managers, who are the next level over the clinical coordinators and who report to department directors. There are a number of units,[4] and the average daily census of patients is approximately 200 - 220.

The Reinstatement Offer to Sandusky

I. Facts

The Board found that Sandusky was unlawfully "laid off" or terminated as a lactation consultant (an RN position) at Audubon on August 9, 1994.

Sandusky has been a licensed RN since approximately 1964. She started working at St. Joseph's, Audubon's predecessor, as a staff nurse in the intensive care unit in March 1975. In January 1980, she transferred to Audubon, where she became a family support specialist in 1986. In 1987, she was certified as a lactation consultant by an international board, as opposed to the State of Kentucky. She performed lactation consulting on a part-time basis prior to performing such full-time beginning on March 25, 1994.

As a lactation consultant, she worked out of the NICU and developed protocols for the care of mothers who were breastfeeding pre-term or high-risk babies. In addition, she worked with some of the problem breast-feeders in the newborn nursery unit and was occasionally called to be a consultant in pediatrics.

Since December 4, 1995, she has worked full-time (37-1/2 hours a week) as a community health care specialist or nurse care manager for Jefferson County, Kentucky. She makes home health visits to low-income prenatal and postpartum mothers, providing education of a medical nature and suggesting resources. Using her personal automobile for transportation, she is reimbursed for her mileage to see clients but not to and from her office. Her reimbursement rate has always been less than the Federal Government's rate.[5]

Pursuant to the Order, the Respondent, by letter of July 12, 2000, from HR director Kees, offered Sandusky a position as a medical/surgical (med/surg) nurse in one of several units.[6] Kees stated that Norton no longer operated a labor and delivery unit or pediatrics department at Audubon and, therefore, the hospital no longer had a lactation consultant position available. She cited Sandusky's experience in pediatric and neonatology nursing but said that no such positions still existed at the hospital. Accordingly, Kees stated,

Norton does have med/surg nursing positions available to which you could be oriented

[4] See patient care services organizational charts, R. Exhs. 145 (September 1998) & 153 (effective September 20, 2002).

[5] See GC Exh. 8.

[6] GC Exh. 5

> . . . . Norton believes that the med/surg nursing positions are substantially equivalent positions. You are hereby offered the opportunity to be reinstated immediately to a med/surg nursing position following reorientation to that position.

Kees' letter implied, but did not directly state, that Sandusky would receive the same pay as the nurse specialist she had been as a lactation consultant. Kees requested that Sandusky contact her to discuss her intentions and interest in the offer. Kees sent a second letter, dated July 25,[7] referencing her earlier letter and asking that Sandusky contact her to discuss the issue no later than 5 p.m. on August 1; otherwise, Kees would assume that she was not interested in one of those positions and proceed with other recruiting.

Sandusky responded by letter dated July 26,[8] stating that the positions offered in the July 14 letter were not "substantially equivalent" to her prior position. First, her prior position as a family support specialist was a higher grade. Further, the adult staff nursing positions were totally outside of her areas of education, experience, and expertise. She pointed out that Norton had the position of lactation specialist at both its downtown and Suburban locations and suggested that an offer in that area would be appropriate in light of her extensive background in maternal-child nursing.

There was no other communication, either written or oral, between them. The record does not reflect whether Sandusky had received Kees' second letter (July 25) when she sent her response of July 26. In any event, both of them considered Sandusky's subsequent failure to respond by the deadline of 5 p.m. on August 1 to constitute a declination of a med/surg nurse position.

Sandusky's testimony about her experience as a med/surg nurse was not fully consistent. She first testified that she never worked in med/surg after Norton took over Audubon in September 1998, but before then worked "occasionally" in such a capacity (Tr. 44 - 46), possibly the last time about 12 years ago. Later, she testified that she never worked in med/surg after she was a student, either in 1963 (Tr. 54) or 1970 (Tr. 55). Such discrepancy is not material because, in any event, her experience in med/surg was quite limited. In 1970, she applied for a part-time job in a med/surg unit at another hospital but was told it would be too costly to orient her, because she had been out of nursing school for over 6 years and had not worked in med/surg.

Sandusky testified that she had no training in med/surg, and all of the nursing positions offered were for adult units. She did not know what to do in med/surg in terms of fully assessing a medical or surgical patient, since different IVs and medications are given to adults vis-à-vis neonatal patients. She did concede on cross-examination that patient assessment is a similar process, whether neonatal or adult, but Clark corroborated her testimony that there are major differences between infants and adults in terms of medications and in taking vital signs.

Sandusky further testified that she had spent thousands of dollars to become a lactation consultant and felt that she would be wasting her education if she went to work in a med/surg unit. Additionally, she had been in a nurse specialist position as a lactation consultant, so she had been two grades above a staff nurse position due to her education and nursing experience. On cross-examination, however, Sandusky conceded that, "Most likely" (Tr. 72), she would have been paid at the higher level of nurse specialist had she returned as a med/surg nurse. Kees

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[7] R. Exh. 1.

[8] GC Exh. 6.

confirmed this. In any event, Sandusky testified that the matter of pay was not the main reason she declined a med/surg position. Rather, it was the status of returning at two grade levels below what she had been.

In addition, she assumed that she would have to lift and ambulate many patients and feared that because of her size, she could not lift heavy patients and could injure her back. She is 62 years old, slightly less than 5-feet tall, and weighs about 85 pounds, approximately her same weight as in July 2000. She testified about one occasion, about 12 years ago, when she had difficulty lifting a patient from a stretcher to the recovery room, because he was too heavy and also because the stretchers were too high for her. She did not believe that she was ever "pulled" to work in med/surg after that.

However, Clark, who is 65 years old and, at most, 5-feet tall, testified that, as a med/surg nurse, she engages in exertional activity, including lifting, transporting, and walking patients. When she requires assistance, either because of the patient's weight or the height of the beds, she obtains it. If no one else is around at the moment to assist, "[I] just have to wait until somebody can come and help . . . . I value my health, my back" (Tr. 182). There are no height or weight restrictions for a staff nurse.

In neither her response letter nor her testimony on direct examination did Sandusky indicate that the reorientation mentioned in Kees' first letter was what concerned her. At the hearing, I asked if she had any knowledge of what reorientation meant. She replied that she understood that there was usually an experienced nurse as a mentor and that she would have to take classes. She then testified that she believed she would have to go back to school for at least a year in order to feel that she could be a nurse on med/surg, an estimated length of time that I find excessive in light of her many years of experience as an RN. She did not inquire further about the reorientation referenced in Kees' letter because, "I [didn't] think it would have been adequate" (Tr. 71). Although no specific details or estimated time frame for reorientation were provided to Sandusky, from the uncontroverted testimony of Kees, clinical manager Ipsan, and staff nurse and preceptor Shawn, it appears that such reorientation would normally entail a combination of classroom and on-the-job training and take from 4 to 8 weeks.

It is undisputed that in July 2000, Audubon did not have a labor and delivery, an NICU, or a pediatrics unit, and that the hospital at that time did not have babies delivered in the standard course of its business. In approximately September 1997, the NICU at Audubon ceased operations, and most of the RNs there transferred to Suburban. General Counsel's Exhibit 16 reflects that the effective date of transfer for those RNs was October 1, 1997. Ipsan, who was the clinical manager of NICU at Audubon and is now clinical manager of NICU at Suburban, testified that she believed all nurses who applied for such a transfer received it. None of those nurses were lactation consultants.

In January or February 1999, the mother/baby unit at Audubon was closed. A number of its nurses were immediately transferred to other Norton hospitals in the area, depending on where there were appropriate positions available. Similarly, in early 1999, the labor & delivery unit at Audubon closed, and many of its RNs went to the labor & delivery unit at Norton's downtown Louisville hospital; at around the same time, Audubon's pediatrics units were closed, and most of the nurses who worked in pediatrics transferred to Norton's Kosair Children's Hospital. In 2000, at the time Sandusky was offered reinstatement, Kosair had openings in neonatal intensive care.

The record reflects that there have been two full-time lactation consultants at Suburban since 1999. One was Lisa Hughes, whose employment records are contained in General

Counsel's Exhibit 17. She was rehired by Suburban in September 1993, as an RN in the mother/baby unit. In December 1998, she applied for promotion to the position of full-time lactation consultant in that unit, and on January 3, 1999, was so promoted. On January 31, 1999, she transferred in that position to the NICU, where she remained until the time of her termination on January 2, 2001, for excessive absenteeism and tardiness. No one replaced her. The second individual is Debbie Moses, who is still employed in that position, out of the mother/baby unit. Her personnel records are contained in Respondent's Exhibits 137 -143. She was hired at Suburban in September 1988, after applying for the position of staff nurse/lactation consultant. In February 1997, she was promoted from being a staff nurse/lactation consultant at Suburban to a full-time position as lactation consultant at Louisville Market, when both hospitals were still owned by Columbia. She later (February 24, 1998) transferred back in that position to Suburban, at least as far as her evaluations were concerned.[9]

No one replaced Sandusky as a lactation consultant at Audubon, and there was no such position in existence at the hospital at the time it was taken over by Norton in September 1998.

Two witnesses called by the Respondent, Ipsan and Shawn, testified without controversion that at some point prior to September 1994 (Ipsan put the time frame as between 6 to 12 months earlier; Shawn as the early 1990s), they were involved in training Sandusky for neo-natal nursing. At the time, Ipsan was a charge nurse, Shawn a staff nurse, in the NICU. Ipsan assigned Shawn to be Sandusky's preceptor in orienting her to take some patient care assignments, because there was not 40 hours' worth of lactation consultant duties. Ipsan and Shawn's unrebutted testimony was that Sandusky had difficulties in learning staff nursing duties in NICU.

II. Positions of the Parties

A number of issues are presented in this rather complex factual situation. I will only address those that have been pursued by the parties in their posthearing briefs. Thus, while the General Counsel's brief asserts that Sandusky mitigated her damages, the Respondent's does not continue to raise failure to mitigate as a defense against liability. Similarly, the Respondent rebuts what it considers to be the General Counsel's prior suggestion that Sandusky should have been offered a position in NICU at Suburban, but the General Counsel does not argue this. Therefore, I conclude that, based on the record evidence, the parties have determined to withdraw from my consideration these issues, and I need not further address them.

The General Counsel contends that the Respondent was obliged to offer Sandusky the position of lactation consultant at Suburban, even if it meant firing her replacement (Hughes), because she would have been able to transfer to Suburban in September 1997, had she not been unlawfully terminated on August 9, 1994.[10] The General Counsel does not argue that the position of lactation consultant encumbered by Moses at Suburban in July 2000 was an applicable position for purposes of the Respondent's reinstatement offer to Sandusky.[11] The

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[9] See R. Exhs. 140 & 141. Kees testified that after Moses' promotion in February 1997, Moses had responsibility for going to several hospitals. Moses did not testify, and the record does not reflect what percentage of her time was spent at Suburban before or after February 24, 1998.

[10] See GC's posthearing br. at pp. 6 -8.

[11] The Union contends to the contrary. See Union's posthearing br. at p. 9. Neither the General Counsel nor the Union assert the existence of any other lactation consultant positions

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General Counsel further contends that the Respondent did not offer Sandusky a "substantially equivalent position," because med/surg was so different from her area of expertise and because of her age and size. Finally, the General Counsel takes the position that Sandusky is entitled, as part of the make whole remedy, for unreimbursed mileage expenses.

The Respondent takes the position that Sandusky was offered a substantially equivalent position in view of the fact that there were no lactation consultant positions or even any mother/baby or neonatal units at Audubon in July 2000; she was offered a salary commensurate to her lactation consultant position and reorientation training; and there were no physical demands that would have precluded her from being a med/surg nurse. The Respondent contends that she is not entitled to recover mileage expenses because she is already reimbursed for mileage.

For the reasons stated below, I find that Sandusky should have been offered a lactation consultant position at Suburban in July 2000 and that the offer made to her at that time for a med/surg nurse position was invalid; that when the lactation consultant position encumbered by Hughes was eliminated on January 2, 2001, there was no longer an existing lactation consultant position available for reinstatement purposes, but the Respondent remained obliged to offer Sandusky a substantially equivalent position; that the position of a med/surg nurse was substantially equivalent; and that the Respondent must renew its offer to her for such a position.

III. Analysis and Conclusions

The first question that must be answered in determining the efficacy of the Respondent's July 2000 offer to Sandusky to be a med/surg nurse is whether Sandusky should have been offered a position as a lactation consultant. The record reflects that Sandusky's position as lactation consultation at Audubon was not filled by any other employees after her unlawful termination in 1994, and no such position exists there today.

However, both in September 1997 and in early 1999, Audubon RNs were given the opportunity to transfer to sister hospitals in the area when their units at Audubon were closed. Sandusky would have been included in the 1997 group had she not been unlawfully terminated in 1994. Accordingly, in terms of Sandusky's reinstatement, I deem it appropriate to consider lactation consultant positions which currently exist at other Norton hospitals. The Respondent cites[12] *Fabsteel Co. of Louisiana*, 231 NLRB 372, 380 (1977), enfd. 587 F.2d 689, 693 (5th Cir. 1979), for the proposition that a job at a different facility is not substantially equivalent employment. That case is inapposite for several reasons. First, in that case, ULP strikers were offered positions in other geographic areas, requiring relocation; second, there was nothing in the record showing that positions did not exist at the facility where they had previously worked; and, finally, the employees had been offered jobs in those other areas. Here, Suburban is in the same city as Audubon, there are clearly no lactation consultant positions at Audubon, and Sandusky has never been offered a position at Suburban.

Since 1994, Suburban has had two persons in the lactation consultant position: Moses and Hughes. Moses was hired as a part-time lactation consultant in 1988—approximately 6 years prior to Sandusky's unlawful termination -- and was never a "replacement" of Sandusky. Accordingly, I do not deem Moses to be a "replacement" employee for reinstatement purposes and, indeed, the General Counsel does not so contend.

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at other Norton hospitals germane to Sandusky's reinstatement.

[12] See R. posthearing br. at p. 15.

As support for its argument that Sandusky should be reinstated as a lactation consultant, to the position formerly held by Hughes, the General Counsel cites *Panoramic Industries, Inc.,* 267 NLRB 32, 38 -39 (1983). The judge therein cited (at footnote 37) *Curtis Mfg. Co., Inc.,* 189 NLRB 192, 198 (1971), wherein a discriminatee was ordered restored to her former position of employment even though it meant firing an employee hired after her termination.

Hughes was hired as a lactation consultant in January 1999, after Sandusky was unlawfully terminated. Based on the above authority, I agree with the General Counsel that the Respondent should have offered Sandusky Hughes' position, even if meant displacing Hughes in that job. Therefore, to the extent that the Respondent did not offer Sandusky a position of lactation consultant in July 2000, the offer of reinstatement was not valid. However, Hughes was terminated on January 2, 2001, and no one replaced her. Thus, there is no "replacement" employee who can be removed from the position for Sandusky's benefit. The Board's order of reinstatement in this case does not require that the Respondent now create a job of lactation consultant when no such job exists: on the contrary, using standard remedial language, the Order explicitly states, "or if such job no longer exits, to a substantially equivalent position of employment." Accordingly, I conclude that the Respondent's obligation to offer Sandusky a position as a lactation consultant ceased at the time that Hughes was terminated and not replaced. Therefore, the Respondent's backpay liability for this aspect of the reinstatement offer extended only through January 2, 2001.

The next question is whether the Respondent's July 2000 offer to Sandusky to become a med/surg nurse, although invalid when made, became valid on January 2, 2001, when the formerly available position of lactation consultant was effectively abolished. I note that since Hughes position has not been refilled, presumably it was determined by management at a certain point that no lactation consultant was needed in her place. It is logical, therefore, to assume that had Sandusky been reinstated to a position of lactation consultant in July 2000, she likely would have been laid off or transferred at some point after January 2, 2001.

In any event, I must now determine whether the July 2000 offer to Sandusky to become a med/surg nurse was valid after January 2, 2001, as constituting reinstatement to a "substantially equivalent position." If this is answered in the affirmative, then the last question is whether the Respondent was under an obligation after January 2, 2001, to reoffer such a position and, if so, when.

The reinstatement letter Sandusky received implied that she would not lose any pay as a med/surg nurse vis-à-vis what she would have been paid as a lactation consultant, and Kees confirmed this in her testimony. The issue of "substantially equivalent" in this case thus does not relate to remuneration but to terms and conditions of employment.

Although Sandusky testified that she did not believe she could handle the physical demands of a med/surg nurse position, Clark, who is of similar size and age, testified that she receives assistance from other staff members when necessary. Moreover, there are no height or weight restrictions for med/surg nurses.

Not having worked as med/surg nurse for many years, Sandusky reasonably concluded that she would require reorientation for the position. Unquestionably, there were differences between her work with newborn babies and their mothers and the types of skills required of handling adult patients. However, the Respondent did offer Sandusky reorientation training. Sandusky assumed it would be a very lengthy process, but she made no inquiries of management to find out exactly what the reorientation would have entailed. I believe she had a duty of inquiry in those circumstances, to obtain more information from the Respondent rather

than to base her conclusions solely on assumptions. From the uncontroverted testimony of management witnesses, it appears that such training might have lasted anywhere from 4 to 8 weeks, far less onerous than the year period that Sandusky testified she feared. Sandusky was an experienced RN and was offered an RN position, albeit not a specialized one, as she had previously held. I conclude that the med/surg position was "substantially equivalent" and, had there been no lactation consultant position at Suburban in July 2000, the offer of reinstatement made by the Respondent would have been valid.

However, I have concluded that there was such a lactation consultant position and that it existed until January 2, 2001. The final question is whether the Respondent, after January 2, 2001, was obliged to renew its offer to Sandusky of a med/surg position, even though she had previously turned it down. Although it could be argued in other contexts that the Respondent should not be required to do so, based on the presumed futility of such an action in light of Sandusky's earlier rejection, this is a compliance proceeding, and the Board has already determined there was unlawful discrimination against Sandusky. Therefore, any questions about compliance obligations on the part of the Respondent should be decided in her favor.

Moreover, Audubon has an established practice of allowing RNs to transfer to other positions when their positions have been eliminated. Based on this, I conclude that had Sandusky been presented with, and accepted, a valid reinstatement offer for the lactation consultant position in July 2000, she would have been able to transfer to other positions (i.e., in med/surg) if her lactation consultant position had been eliminated after January 2, 2001.

Based on these considerations, I conclude that the Respondent, since January 2, 2001, has remained under an obligation to renew its offer to Sandusky to work as a med/surg nurse and that the Respondent's backpay obligation continues until such time as that offer is made.

Finally, as to mileage reimbursement, I find that Sandusky is entitled to the amount calculated by the General Counsel. It is well-established Board law that travel expenses a discriminatee incurs in maintaining interim employment, beyond what she would have incurred had she continued working for the subject employer, are properly deducted from interim earnings (or, conversely, are reimbursable). *Uarco, Inc.*, 294 NLRB 96, 102 (1989); *Aircraft & Helicopter Leasing*, 227 NLRB 644, 649 (1976), enfd. 570 F.2d 351 (9th Cir. 1978); *Hoosier Veneer Co.*, 21 NLRB 907, 938 fn. 26 (1940). This result logically flows from the broader precept that in compliance proceedings, the Board attempts to reconstruct "'as much as possible,' the economic life of each claimant and place him in the same financial position he would have enjoyed 'but for the illegal discrimination,'" *Cobb Mechanical Contractors*, 333 NLRB No. 142, slip op.1 (2001), citing *Phelps Dodge Corp.*, 313 U.S. 177, 194 (1941).

The Offers to Clark and Hurst

I. Background

As noted earlier, both Clark and Hurst have remained employed as RNs at Audubon since they were unlawfully denied promotion to patient care leader (now entitled clinical coordinator) in mid-January 1996. The Order required the Respondent to offer them such promotion. Issues relating to the validity of the July 2000 offers the Respondent made to them are intertwined with the issue of whether clinical coordinator is a statutory supervisory position within the meaning of Section 2(11) of the Act.

The Board adopted Judge West's determination that the patient care leaders were not statutory supervisors within the meaning of section 2(11) of the Act. It is not necessary for me

to recite in detail all of his specific findings in this regard. Suffice to say, he concluded that the functions performed by the patient care leaders which went beyond patient care were routine in nature and did not require the use of independent judgment under Section 2(11) of the Act. He therefore included them in the unit.

The Respondent contends that I should revisit this issue, in light of developments in the law that occurred since the hearing in the previous case concluded on February 12, 1996, and the Order issued on June 22, 2000, in particular, the Supreme Court decision in *Kentucky River Community Care, Inc.*, 532 US 706 (2001). The Respondent further contends that the clinical coordinators have been supervisors under the Act since the time when it took control of the hospital in September 1998. The General Counsel and the Union take the position that the clinical coordinators were properly deemed unit employees in the prior case and remain so.

II. Facts

By letters of July 14, 2000,[13] the Respondent offered Hurst and Clark, respectively, positions as charge nurses, pursuant to the Order. In said letters, Kees stated,

> The Charge Nurse position has evolved since [September 1, 1998] to include more management responsibilities. Effective March 1, 2000, Norton transitioned to change Charge Nurse positions with a revised Job Description reflecting the increased management responsibilities of the position.
>
> It is the position of Norton that the Charge Nurse position is a substantially equivalent position to the Patient Care Leader position which was abolished at Norton. Accordingly, Norton is prepared to offer you a Charge Nurse position. Enclosed herewith you will find a copy of the current Job Description for the Charge Nurse position at [Audubon]. Further, you should be advised that is the position of Norton that persons occupying regular Charge Nurse designations . . . are supervisors within the meaning of [the Act].

Hurst was offered a full-time (1.0 status or 40 hours per week) position as charge nurse on CVU, and Clark was offered a full-time position as charge nurse on unit 3E, with accommodation for her then-existing medical restriction. Charge nurse job descriptions were attached.[14]

By letters dated July 24 and 26,[15] respectively, Clark and Hurst responded identically that:

> I am concerned that the job offer of July 14, 2000 as it is stated in your letter would be supervisory and would therefore deprive me of my Section 7 rights under federal law. The offer, as you place it, would end my freedom to participate in union and concerted activity. This is a problem for me, and I need some time to consider this.

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[13] GC Exhs. 18 & 20.

[14] Kees testified that she initiated a complete revision of all job descriptions after she became HR director at Audubon in July 1999.

[15] GC Exhs. 21 & 19, written on union stationery. Both Clark and Hurst are listed on the letterhead; Clark as president, Hurst as an executive board member. Sandusky is also named as a board member.

> . . . . As the Nurses Professional Organization, we have a written protest to the NLRB over this matter, and I would like to await the outcome of that protest.

There was no further communication between the Respondent and Clark and Hurst regarding the offers. Clark (who is still union president) and Hurst testified, consistently with their response letters, that they declined the offers because they did not wish to give up their right to engage in union activity.

III. The Legal Framework

Here, the Respondent conditioned its offers of promotion to clinical coordinator (charge nurse) on the employees' acquiescence in the Respondent's assertion that clinical coordinators are statutory supervisors. The offers contained the clear message that the employees would forfeit their rights to engage in union activities if they accepted promotion.

Preliminarily, I do not conclude that the Respondent, in contending that the clinical coordinators are supervisors, was motivated by a desire to place Clark and Hurst, two of the most identified Union leaders, in an untenable position. Nevertheless, I must determine whether the Respondent placed a condition on the offers that invalidated them, with the result that its backpay obligations to Clark and Hurst continued past July 2000, and further offers of promotion must be made.

It is well established that an employer has the burden of proving that it made a valid offer of reinstatement tolling its backpay obligation and that such offer was sufficiently unequivocal and unconditional. *Beverly Cafeteria Corp.*, 329 NLRB 977 (1999); *Tony Roma Restaurant*, 325 NLRB 851 (1998). I therefore reject the Respondent's contention, made at the hearing, that Clark and Hurst could have accepted the offers and later contested the Respondent's position in a ULP proceeding, or through some other means. That would have placed them in a very difficult situation, particularly because it would appear that an employer, after a reasonable period of time, can discharge an employee reinstated to a supervisory position for continuing to engage in union activities. See *Oil, Chemical & Atomic Workers International Union*, 547 F.2d 575, 589 fn.16 (D.C. Cir. 1976). The Board has already found that Clark and Hurst were the victims of unlawful discrimination, and placing the onus on them to challenge the Respondent's legal assertion that clinical coordinators are supervisors would be unfair and unreasonable. In any event, as noted above, the burden is on the employer to show that its offer was not conditional, not on the employee to accept a condition and later challenge its validity.

Significantly, this is not a case of first impression on the issue of the status of clinical coordinators. The month before the July 2000 offers were made, the Board found that the position was nonsupervisory and included in the bargaining unit.

In light of these considerations, I conclude that the Respondent, although certainly free to believe and argue that the status of clinical coordinators had changed since the ULPs had been committed by its predecessor, acted at its peril in unilaterally deciding that the position was now supervisory and that it could force Clark and Hurst to choose between the promotion and remaining active in union affairs. See *Central Cartridge, Inc.*, 236 NLRB 1232 (1978), in which the Board held invalid an employer's offer to reinstate an employee "as a supervisor," when the position was ultimately determined to be nonsupervisory.

For the reasons stated below, I find that the clinical coordinators are not statutory supervisors within the meaning of Section 2(11) of the Act and that the Respondent's offers of promotion to Clark and Hurst were invalidated by the imposition of an improper qualification.

IV. The Status of Clinical Coordinators

A. Facts

Considerable evidence, documentary and testimonial, was presented on this issue. Although two time frames are relevant (July 2000, when the offers were made, and the present), none of the parties have contended that there have been any significant changes in the role and duties of clinical coordinators since July 2000. I also note that the large number of nursing units and staff, described earlier, may understandably result in some variations in the application of hospital-wide policies and procedures.

I give most weight to the testimony of Randa Bryan, Christopher Brown, and Ladonna Thomas, for the following reasons. All three answered questions readily and without hesitation, appeared candid, and did not appear to make any efforts to skew their answers to make clinical coordinators supervisory. They were generally quite consistent in terms of hospital policies and the practices with which they are familiar. Significantly, Brown and Thomas are now clinical managers but have had experience as clinical coordinators.

Brown is the clinical manager for a 36-bed med/surg unit. He normally supervises three clinical coordinators and reports to the unit's director. Before becoming clinical manger in March 2000, he was a clinical coordinator in the intensive care unit since late 1998 or early 1999. His testimony primarily concerned his relationship as clinical manager with the clinical coordinators who report to him. Bryan has been manager of the ER since 2001. Prior thereto, she was simultaneously the manager of several units from January or February 1998 on. She supervised about 130 -34 employees, of whom about three-fourths were RNS and 11 were clinical coordinators. Bryan's testimony sometimes related only to her previous position as manager of several units, but at other times was based on her current position. Thomas has been the manager of the open-heart unit for about a year; before that, she was a clinical coordinator in one of the open-heart units (under Bryan) and supervised about 30 RNs. Her testimony generally related to her experience as a clinical coordinator.

Kees and Clark also testified in detail on the status of clinical coordinators. Kees was generally credible, but she is more removed from day-to-day operations by virtue of her position in higher management. The same holds true for witness Mary Gruebbel, who has been vice-president for patient care services for Norton Health Care since September 1, 1998. Patient care services entails in-patient units, emergency services, and surgical services. Moreover, Gruebbel's testimony was quite limited in scope.

In contrast to her credible testimony on direct examination, Clark's testimony on rebuttal was only partially credible. In the latter, on matters relating to RN scheduling, her answers were direct, clear, and confident. However, on the subject of the authority of clinical coordinators, and RNs in general, she was markedly evasive and non-responsive.[16] Further, recognizing the medical hierarchy and the greater status and medical knowledge that RNs possess, compared to Licensed Practical Nurses (LPNs), I find implausible her testimony that as an RN or even as an acting clinical coordinator, she has no authority over LPNs who are not correctly performing their patient care responsibilities. However, inasmuch as I do not find it necessary to rely on this aspect of her testimony for any of my factual or legal conclusions in this case, I need not further discuss it.

[16] See Tr. p. 603, et seq.

i. General Role and Status

Job descriptions for clinical coordinators and clinical managers, used through the years, are contained at Respondent's Exhibits 146 –152. Inasmuch as formal job descriptions are not dispositive of supervisory status, I will not set out their contents here. Suffice to say, the basic description of the duties of clinical coordinator has not changed significantly since at least February 12, 1998,[17] albeit there has been some changes in nomenclature and in format, and an expansion of enumerated responsibilities.

Kees testified that there has been an initiative by Norton since September 1, 1998, to ensure that clinical coordinators are positioned to assist charge managers in running their departments. Operations at the hospital are continuous, 24 hours a day, 7 days a week, and managers cannot be there all the time. Part of this initiative involved getting more clinical coordinators to participate in evaluations and discipline on a formal basis. A training program for clinical coordinators was instituted, wherein they received training on how to fill out an evaluation, how to coach and counsel, and how to prepare a performance improvement plan (PIP). They were also trained on how to interview, such as at job fairs, but recruitment techniques have changed since then. A management development program was extended on January 1, 2001, to all supervisors, including clinical coordinators, who now receive such training. Clinical coordinators work with educators (nonstaff nurses) in the orientation of new employees, but educators and preceptors (staff nurses) are the ones who decide whether an employee passes his or her orientation.

Although Kees testified that clinical coordinators may interview and hire new employees, neither she nor any other witness of the Respondent gave any specific instances or numbers. In any event, she testified that actual hiring is done through HR, which makes the formal job offers. Therefore, I need not further address clinical coordinators' role in this area.

Brown and Bryan testified very similarly as to their view of the role of clinical coordinators. Thus, Brown testified that "clinical coordinators are my eyes and ears" (Tr. 384), while Bryan testified that when she was clinical manger of several units, she saw them as "extensions of myself . . ., my right arm" (Tr. 436). Both testified that clinical coordinators run the unit and make decisions in the absence of the clinical manager. Brown's clinical coordinators keep him informed of all staff situations that arise in his absence, either by pager or phone or when he comes in the next day. They discuss the issue and determine what needs to be done. Bryan worked almost 12-hour days and was accessible 24 hours a day.

Clinical coordinators, as well as acting clinical coordinators ("clock charge nurses") receive a 5-percent pay differential an hour. They do not receive any other benefits vis-a-vis staff nurses. As Brown and Thomas testified, when clinical coordinators are not engaged in clinical coordinator duties, they perform patient care services as RNs.

ii. Role in Evaluations and PIPs

Respondent's Exhibits 5 through 134 represent nursing staff personnel records from January 1, 2000, to the present. Included are evaluations of RNs, LPNs, nurses' aides or patient care associates (PCAs), technicians, and unit secretaries. Most are annual reviews, a few 6-month or transitional (probationary) evaluations. Most were signed by both a clinical

[17] Compare, R. Exh. 146, job description in effect on February 12, 1998, with the current job description, R. Exh. 150.

coordinator and a clinical manager, although not always on the same date. Some had notations written by clinical coordinators and/or clinical managers.

Kees testified that such evaluations have been used for developmental and nonmonetary—morale—rewards, or "pats on the back" (Tr. 165). In 2000, all increases were at the same percentage amount, regardless of an employee's evaluation.

Kees additionally testified that evaluations, transitional (probationary) or annual, are given to the employee either by the clinical coordinator or the clinical manager. However, the similar testimony of both Brown and Bryan reflects that the clinical managers review the proposed evaluations made by clinical coordinators, have the authority to change them, and may do so on occasion. Thus, Brown testified that in the 90-day evaluations of new employees, clinical coordinators have significant input because they are directly involved in patient care activities. He candidly stated on direct examination that, in terms of regular or annual evaluations presented to him by clinical coordinators, he has disagreed with their ratings on a few occasions and changed them.

Bryan testified that clinical coordinators filled out evaluations. For the most part, she trusted their judgments and rarely made her own comments. Sometimes, she questioned a clinical coordinator about the rating level assigned. Although she did not make the clinical coordinator change the rating in that situation, the latter had to support it. She could not recall a particular time when she made a clinical coordinator change a rating but testified that it was possible that may have occurred. Thomas testified that when she was a clinical coordinator under Bryan, Bryan accepted all of the transitional (90-day) or yearly evaluations she wrote.

Regarding PIPs, Kees testified that they are not disciplinary but can result in discipline if there is lack of improvement. Further, PIPs resulting from an annual evaluation are "unusual" (Tr. 287). According to hospital policy, the department director must concur in the decision to place an employee on a PIP. Kees is consulted for approval of a PIP before there is a meeting with the employee by either the clinical coordinator, clinical manager, or director, or a combination thereof. Although department managers have the authority to change the decision of someone below as to placing someone on a PIP, she was not aware of any instances in which this has occurred. She could not give any examples of when a clinical coordinator has made the final decision as to whether someone passed or failed a PIP. Bryan's testimony on the subject was generally consistent with Kees. She and her clinical coordinators worked together to formulate and implement PIPs, and the clinical coordinators were responsible for overseeing it. Putting someone on a PIP was a joint decision between her and the clinical coordinator, but she had the ultimate decision-making authority. She agreed with the clinical coordinator approximately 95 percent of the time. She could not think of any situations when the clinical coordinator implemented a PIP without talking to her.

Kees testified that an employee who does not pass the transitional 90-day evaluation may be given additional time to improve. A clinical coordinator can extend the transitional period, but a clinical manger or director of the unit would have to decide whether to accept such recommendation. Brown's testimony comported with hers. He testified that if a probationary employee needs extension of the orientation period, he is the one who can extend it, placing "significant reliance" on the recommendation of the clinical coordinator (Tr. 393). Only once or twice during his tenure as a clinical manager has the 90-day period been extended, and on those rare occasions, he followed the recommendation of the clinical coordinators.

Regarding an employee's transfer to another department, that can result from failure to pass a PIP, Kees testified that a clinical coordinator or clinical manger can exercise that

authority. However, she could not cite any specific occasions when a clinical coordinator has actually exercised such authority, and she conceded that even though a clinical coordinator may initiate a transfer, the clinical manager is to going to be involved. In any event, she testified, it is the employee's decision in those situations whether or not to accept the transfer.

In summary, based on the above, I find the following:

1) Annual evaluations do not result in any financial impact on employees or in the direct imposition of any form of discipline,
2) Ninety-day probationary periods are rarely extended based on evaluations, and the record does not establish that anyone has been terminated based on a 90-day evaluation.
3) Clinical coordinators prepare evaluations but must discuss them with clinical managers, who retain the authority to change them and occasionally do so.
4) Clinical coordinators have significant input into putting someone on a PIP, but the ultimate decision-making authority lies with clinical managers, with required participation by HR.
5) PIPs are rarely imposed.
6) Clinical coordinators may initiate employee transfers, but clinical manager must become involved and, ultimately, the subject employees decide whether or not to accept them.

iii. Role in Discipline

At all times material, the Respondent has maintained a progress discipline policy, last revised on January 1, 2001,[18] providing for four levels of offenses, with points assigned to each.

Kees testified that the clinical coordinators, depending on the situation and time of day, can decide if something needs to be done when there is a complaint against an RN. As to disciplining other employees, Kees testified that when no house supervisor (the contact person for the administration) or unit manager is on duty, clinical coordinators can issue oral or written warnings or even suspend. However, she could not say whether, when they issue written warnings, they first check with clinical managers. In any case, she testified that she is consulted about a written warning, either before or after it is issued, depending on her availability. She is also consulted if something is unclear or the situation novel. When it comes to disciplinary suspension, the last step before termination, Kees testified that the clinical manger or director is normally involved. She was not aware of any specific occasions when a clinical coordinator suspended someone on his or her own. Terminations require the involvement of clinical mangers or clinical directors, who ultimately possess the final decision-making authority.

Although either a clinical coordinator or a clinical manger can place someone on investigatory suspension, Kees was not aware of any situations in which a clinical coordinator did so on his or her own without talking with someone else. Typically, the clinical coordinator will call the house supervisor.

Kees testified that if an employee shows up impaired, and substance abuse is suspected, either a clinical coordinator or management can send the employee for a drug screen; nobody sends the employee home. According to Brown, if an employee shows up intoxicated, the clinical coordinator should notify the house supervisor and get the employee removed for testing. Under either scenario, clinical coordinators do not possess the authority to send such employee home.

[18] See R. Exh. 135.

Brown, Bryan, and Thomas testified about their first-hand knowledge of how the disciplinary process operates. In determining whether discipline is warranted, Brown and his clinical coordinators refer to the handbook and, if deemed necessary, consult with HR. In recommending disciplinary action, clinical coordinators are well versed in the employee handbook, and their recommendations have to be consistent with hospital policies. Points are assigned depending on the infraction. Disciplinary decisions are never made solely by the clinical coordinator; they always consult with him. Eighty to 90 percent of the time, he accepts their recommendations for minor disciplinary action (levels one and two misconduct). If more serious misconduct is involved, or there is a question, he contacts HR for input. He makes the ultimate decision on the discipline imposed, in consultation with the clinical coordinator and/or HR. He always investigates incidents of employee misconduct, even if they are only a level one.

Bryan expected her clinical coordinators to address disciplinary situations on the spot. If they needed more advice, they would contact the house supervisor or her by beeper, usually the former. Generally, although clinical coordinators participate in discussions, managers have the final decision-making authority with respect to discipline and normally also discuss it with HR. Only seldom (approximately 5 percent of the time) has she disagreed with clinical coordinators' recommendations concerning discipline.

As a clinical coordinator under Bryan, Thomas had about 30 RNs under her. She was the immediate supervisor for the unit, and when she saw problems, she addressed them immediately and documented them, typically in the form of anecdotal notes. Some of those were put into the employees personnel file, but others were not. When lesser discipline was involved, such as for attendance, she handled it directly with the employee. However, in situations entailing serious discipline (written warning or above), or placing an employee on a PIP, she always informed Bryan, who always sat in on her discussion with the employee.

For the reasons previously stated, I give more weight to the testimony of Brown, Bryan, and Thomas on the authority of clinical coordinators to issue discipline than I do to the testimony of Kees, and I find such authority to be more limited in practice than Kees stated it to be from her vantage point of higher management.

Brown testified that all RNs have some authority over LPNs in terms of the latter performing their job duties. The PCAs know their job duties and function independently. If they are not performing correctly, either a clinical coordinator or a staff nurse can make suggestions for improvement. Clark testified, not inconsistently, that if a PCA is not doing the job right, usually the RN who has the patient will bring this to the PCA's attention. However, as noted earlier, her subsequent testimony about clinical coordinators and RNs lacking authority over LPNs in patient care situations was not credible.

There is a well-defined attendance and tardiness policy,[19] separate and distinct from disciplinary misconduct in general. Kees testified that this policy is very detailed and that when an employee reaches a certain number of "occurrences," a fixed level of discipline is automatically triggered. If there is a question of what constitutes an occurrence, HR is typically called in to decide. Kees stated that Norton tries to have a fairly tight policy on absences, so that the policy is easy to apply and avoids issues of interpretation. Accordingly, there is little discretion involved in a clinical coordinator's determination of what constitutes an absence. In

[19] See R. Exh. 136.

Respondent's Exhibits 5 – 134, there are several attendance counseling notices,[20] most signed by both a clinical coordinator and a clinical manager.

Bryan testified that if an employee had an attendance problem, she and the clinical coordinator would discuss it, and she would advise the clinical coordinator how to proceed, following the employee handbook. For example, at six absences, there would be a first write-up, which the clinical coordinator would prepare and show to her for approval. Once she approved it, the clinical coordinator would carry it out. Consistent with Kees, she testified that generally there is no question what constitutes an occurrence for attendance discipline and little discretion involved in application of the attendance policy.

In summary, based on the above, I find as follows:

1) Hospital disciplinary policies are formalized, and HR is consulted if there are any questions about their application or if major disciplinary action is proposed.
2) Clinical coordinators play a role in employee discipline, but they normally consult with their clinical managers, and always do so when serious discipline (written warning or above) is proposed.
3) The final decision to impose discipline rests with clinical managers, who normally, but not always, accept the recommendations made by clinical coordinators for minor disciplinary actions.
4) Attendance and tardiness policies are highly detailed and intended to be easy to apply, leaving little room for discretion in terms of their implementation. Their application is largely automatic. If there are any questions about application, HR is consulted.
5) All RNs possess a certain amount of authority over LPNs and PCAs when it comes to the latter's provision of patient care.

iv. Role in Scheduling and Assignments

Gruebbel testified that scheduling grids are used as a guide to develop staffing patterns, which are an administrative exercise, in conjunction with clinical managers, clinical coordinators, finance people, and others. These staffing patterns are utilized as a baseline for how many RNs, LPNs, and PCAs should be on a particular shift. Other considerations for staffing include patient needs, the competency of the staff, and demands of family members. Typically, clinical coordinators make the staffing decisions, in coordination with the house supervisor. If they have concerns or questions, they may involve the clinical manager.

Kees testified that clinical coordinators make arrangements with the house supervisor to have the appropriate number of people (RNs and other staff members) on their unit, in order to have a balanced schedule[21] and provide the greatest continuity in patient care. This is based on guidelines, taking into consideration the number of patients and their acuity. They also mark staff staffing time sheets for payroll purposes. Kees did not know who approves leave requests made by RNs, opining that it might be different from unit to unit. Long-term leave requests go up to HR. The clinical coordinators call in nurses for emergencies

Brown testified that clinical coordinators are responsible for delegating all assignments, determining which nurses will take of which patients, and directing patient care. The normal staffing of his unit on a particular shift is one clinical coordinator, two RNS, three LPNs, three -

[20] R. Exhs. 102, 111, 123, & 129.
[21] See GC Exh. 28, a 6-week schedule.

four PCAs, and one - two unit secretaries, for a total of 11 -12 employees excluding the clinical coordinator. The clinical coordinators constantly, but not continuously, direct work. Brown does the scheduling. Clinical coordinators handle changes in assignments that need to be made during shifts. In those situations, they sometimes come to him, other times they do not. If financial ramifications are involved, such as overtime pay or canceling someone's duty, Brown is involved.

Further, Brown testified, the clinical coordinators daily assign duties to staff nurses. In determining what patients are assigned to what nurse, the clinical coordinator considers the acuity of patients, the continuity of care, and the skill level of the nurses. If two nurses want to shift assignments, they can obtain approval from the clinical coordinator. When it comes to sending a nurse to another unit, the house supervisor, in conjunction with the clinical coordinator, follows detailed staffing guidelines. This is the procedure whether or not Brown is present. There is always a house supervisor available, and clinical coordinators frequently call the house supervisor on duty. Authorization of overtime is an administrative matter. Brown has such authority, but the clinical coordinators do not.

Bryan testified that staffing standards are management engineered. Weekend work follows a set pattern of assignments. Each unit does its own self-scheduling, and employees have input into how they want their schedules to be. Once the schedules are posted, employees can decide among themselves to trade, and they then notify the clinical coordinator. If an employee cannot come in, he or she should call both the clinical coordinator and the house supervisor. Clinical coordinators make assignments of nurses and draw up 6-week schedules. Bryan has the final authority on scheduling and sometimes tells a clinical coordinator to redo the schedule, although she rarely does not accept their non-holiday schedules. In terms of scheduling around holidays, Bryan considers seniority and equity and makes the final decision.

When Thomas was a clinical coordinator under Bryan, she testified, the staffing pattern guidelines in effect provided that each nurse normally had two patients; only one if the patient was in the open-heart area or was acutely unstable. Bryan made the staffing pattern, based on a rate of one nurses per two patients; for 16 patients, there would normally be one clinical coordinator, eight RNs, and two PCAs. If Thomas determined, on the basis of her experience as a critical care RN, that the acuity of patients warranted deviation from this, she could staff additional nurses. She would then call from the list on the charge board of staff members in the unit, as well as registry employees. In her unit, employees were not required to come in when they were unscheduled, although she had the authority to mandate it. If she found herself overstaffed, the practice was to first cancel agency people (the most expensive), followed by premium-pool people and, finally, regular staff based on a rotating list. This procedure was fairly routine for the most part, although the experience and performance levels of the RNs needed to be considered.

As a clinical coordinator, Thomas received an overview of the patients in unit and looked at the surgery schedule. She assisted with procedures and patient care at times, depending on the staffing level. She made assignments not only to RNs but also to other employees on the unit. Depending on the number of patients and their acuity, she determined the staffing level for the upcoming shift and either called in additional staff or cancelled nurses if the census was down. Typically, she did this on her own, determining whom to call on the basis of specific needs and the qualifications of the nurses.

As to the 6-week schedule, it was a modified self-scheduling system. Nurses put down their desired schedules, with some minor requirements. She would have to move around employees if necessary. Once Thomas felt the schedule was ready, she presented it to

manager Bryan, who always accepted her proposed schedule.

In contrast to Clark's unsatisfactory testimony on the subject of the authority of clinical coordinators/RNs over other staff employees, Clark testified credibly on the matter of how assignments are handled, and I credit that portion of her rebuttal testimony. She testified that the procedure for clinical coordinators making assignments has remained the same over the past several years. The first thing looked at is continuity of care and the acuity of patients, so that no one nurse is overloaded. There is usually a sheet available showing indicia of the need for more intensive patient care, such as IV pushes, no codes, and patients in isolation. The nurses talk among themselves about patient needs. Staffing patterns designed by management are used to show how many RNs are needed. The house supervisor calls the staffing to the clinical coordinators. When Clark is a clock charge nurse or an acting clinical coordinator, she checks to see how many nurses are scheduled and what their assignments are; assignments were made by whoever was in charge the night before. Near the end of the shift, as an acting clinical coordinator, she checks the census and makes assignments according to what nursing services said would be the level of staffing. If she determines the unit is understaffed, she calls the house supervisor and requests more help. The answer is normally no, because they do not have anybody else to schedule. Then, she usually goes to the rotation sheet, which shows who is working the shift before and whose turn it is to be "mandated" to stay over into the next shift.

As an acting clinical coordinator, Clark has never ordered anyone to come in who is not scheduled. When an employee is unable to come into work, he or she is supposed to call nursing services and also their unit. She is not aware that clinical coordinators can give permission for someone to be off work. When she is an acting clinical coordinator someone wants to leave early, she tells them to go to the house supervisor or nurse manager, if available. Should someone call in that he or she will be late, Clark informs nursing services and her supervisor.

Based on the above, I find in summary, that:

1) Employee preferences play a large role in their scheduling, and employees normally are able to make changes in their schedules among themselves.
2) Staffing guidelines, developed by management, are used to set up 6-week schedules of all employees in a unit and also come into play when employees need to be transferred to other units during their shifts.
3) Six-week schedules are drawn up either directly by clinical managers, or by clinical coordinators who must then have them reviewed by clinical managers. Clinical managers may exercise their authority to direct clinical coordinators to redo them.
4) If unit-staffing changes need to be made during shifts, clinical coordinators have this responsibility, and they consider a number of factors, including staffing guidelines, acuity of patients, continuity of care, and qualifications of available employees. Clinical managers may require that they be involved in the decision, if there are financial consequences for employees. Clinical coordinators cannot authorize overtime.
5) There are set procedures for determining the order of cancellation of scheduled employees and for calling in unscheduled employees. The record does not reflect that any employees have been "mandated" to come in when they have not been scheduled.
6) The house supervisor is normally involved if there is the need to transfer an employee to another unit.

B. Analysis and Conclusions Regarding the Status of Clinical Coordinators

The Board has long held that burden of proving supervisory status rests with the party asserting that status. *Michigan Masonic Hospital*, 332 NLRB No.150 (2002); *Vencor Hospital - Los Angeles*, 328 NLRB 1136 (1999); *Youville Health Care Center, Inc.*, 327 NLRB 237 (1998). Because supervisors are excluded from the protections of the Act, the Board is cautious in finding supervisory status. *In re Franklin Hospital*, 337 NLRB No. 132, slip op. 8 (2002); *St. Francis Medical Center-West*, 323 NLRB 1046, 1047 (1997); *Chicago Metallic*, 273 NLRB 1167, 1688 -1689 (1985); *Vencor,* at p. 1138. The Supreme Court, in *Kentucky River,* upheld the Board's placement of the burden of proof when it comes to supervisory status.

As I noted earlier, this is not a case of first impression when it comes to the status of the Respondent's clinical coordinators — the Board has already determined in the Order underlying this proceeding that, at least in years past, the position was not supervisory. Accordingly, the Respondent also has the burden of establishing that their duties and responsibilities have changed significantly enough to now find them supervisors within the meaning of Section 2(11) of the Act.

Regardless of these burden of proof issues, in the interest of providing a full and fair hearing, and recognizing the change in management, as well as the years that have elapsed since Judge West held the hearing (the last day of which was June 6, 1996), I allowed the Respondent and the other parties considerable latitude in presenting evidence on the issue. As the Sixth Circuit Court of Appeals stated in *NLRB v. Kentucky River Community Care, Inc.*, 193 F.3d 444, 452 (1999), "Whether an employee is a supervisor is a highly fact-intensive inquiry, and therefore, each case must be scrutinized carefully."

The starting point for substantive legal analysis of whether the clinical coordinators are statutory supervisors is the Supreme Court's decision in *Kentucky River.* The Court in that case rejected what it viewed as the Board's approach of categorically excluding the "professional judgment" exercised by RNs over less-skilled employees in performing patient health care, from the normal application of the concept "independent judgment" to determine supervisory status (see 532 U.S. at 721). The Court reiterated its holding in *NLRB v. Health Care & Retirement Corp.*, 511 U.S. 570, 581 (1994), that professional employees such as RNs should be treated no differently from other employees for purposes of determining whether they possess indicia of supervisory authority within the meaning of Section 2(11) of the Act. I will now turn to those indicia.

The Respondent presented a great deal of evidence regarding the clinical coordinators' role in annual and probationary employee evaluations. However, the preparation of evaluations is not in and of itself enough to constitute an indication of supervisory status within the meaning of the Act. Preparing evaluations that do not lead directly to personnel actions which affect either the wages or job status of employees does not rise to the level of the exercise of supervisory authority to evaluate. *Williamette Industries, Inc.*, 336 NLRB No. 59 (2001); *Elmhust Extended Care Facilities, Inc.*, 329 NLRB 535 (1999); *Vencor Hospital*, 328 NLRB 1136 (1999); *McAlester General Hospital*, 233 NLRB 589, 591 (1977). Moreover, the burden is on the party claiming supervisory status to establish that the evaluations in fact result in personnel actions affecting either employees' wages or job status. *Elmhurst Extended Care,* at p. 536.

Here, Kees testified unequivocally that the evaluations prepared by clinical coordinators had no impact on wages — employees receive a fixed rate of increase regardless of their evaluations. Positive evaluations have been used for morale and development purposes only.

Unfavorable evaluations rarely result in the imposition of PIPs and, in any event, PIPs are not considered disciplinary in nature. The record does not establish a single instance where anyone was suspended or terminated for not improving pursuant to a PIP and, therefore, I cannot find that evaluations have resulted, even indirectly, in any imposition of discipline.

Even if the impact of the evaluations was such as to elevate them to an exercise of supervisory authority, the clinical coordinators do not have the final authority to issue them. The Respondent's own witnesses directly involved in the process of evaluations confirmed that the clinical managers uniformly review evaluations prepared by the clinical coordinators and possess, and occasionally exercise, the authority to change them. Similarly, transfers may be initiated by clinical coordinators, but clinical managers must review their recommendations and make the final determination, and the employees involved must decide whether or not to accept them. I conclude, therefore, that the role clinical coordinators play in the evaluation process does not constitute supervisory authority within the meaning of Section 2(11) of the Act.

In terms of playing a role in discipline, the record reflects that clinical coordinators have authority on their own to, at most, issue oral warnings or informal counseling memoranda that may or may not be placed in an employee's personnel file and do not constitute formal disciplinary actions under the progressive discipline system. The authority to issue low-level discipline, such as oral warnings, does not in and of itself demonstrate supervisory authority. *Ken-Crest Services*, 335 NLRB No. 63 (2001); *Ohio Masonic Home*, 295 NLRB 390, 393 -394 (1989). Clinical managers have the final authority with regard to discipline, and a clinical manager may decide to be involved in all disciplinary matters and to reject a clinical coordinator's recommendation even in the imposition of minor discipline. Moreover, there is nothing in the record to demonstrate that any employee has ever been suspended or terminated as the result of any issuance of discipline by a clinical coordinator, even if such were issued without the participation of the clinical manager.

Insofar as attendance counseling is concerned, there are detailed written policies that are designed for easy application and allow little room for any exercise of discretion. If there are any questions about application of the policy, HR is consulted. I find, therefore, that any clinical coordinator involvement in the application of attendance policy requires little or no independent judgment.

In sum, the independent authority clinical coordinators possess to discipline other employees, or to effectively recommend such, is very limited and falls far short of establishing that they exercise any real meaningful authority. As the Supreme Court stated in *Kentucky River* (at 713), "Many nominally supervisory functions may be performed without the 'exercis[e] of such a degree of . . . judgment or discretion . . . as would warrant a finding' of supervisory status," citing *Weyerhauer Timber Co.*, 85 NLRB 1170, 1183 (1949).

Finally, with respect to scheduling, assigning, and directing other employees, it again appears that the clinical coordinators do not exercise much discretion. Employees themselves play a large role in how they are scheduled, are allowed to trade schedules among themselves, and are not forced to come in when they are not scheduled. The 6-week schedules are based on management guidelines and are the prerogative of the clinical managers, who either prepare the schedule or delegate such to the clinical coordinator, subject to the clinical manager's review and acceptance or rejection.

If more or less staff is needed during a shift, the house supervisor is involved, and there are express policies setting out who should be called in or who should be cancelled. Transferring employees to other units during a shift requires the involvement of the house

supervisor.

When changes need to be made in patient care assignments within the unit, the clinical coordinator has that responsibility, based on staffing level, patient acuity, and the qualifications of the available staff. It appears, however, that such decisions would be based primarily on the clinical coordinator's knowledge and experience as an RN. Indeed, not only clinical coordinators but staff nurses have authority over LPNs and CNAs when it comes to the administration of patient care.

I conclude that any authority the clinical coordinators have to schedule and call in or cancel employees is quite circumscribed and is governed by fixed parameters set by the employer, leaving little room for the exercise of discretion. See *Express Messenger*, 301 NLRB 651, 654 (1991); *Bay Area*, 295 NLRB 1063, 1077 (1985); *Driftwood Convalescent Hospital*, 217 NLRB 1026 (1975). To the extent that clinical coordinators can direct LPNs and PCAs, such authority inheres in the role of an RN in a hospital setting. The authority of clinical coordinators to reassign RNs to care for other patients involves the Issuance of low-level orders not constituting supervisory authority. See *Polynesian Hospitality Tours*, 297 NLRB 228, enfd., 920 F.2d 1 (DC Cir. 1990). I note that the clinical coordinators do not even possess the independent authority to transfer employees to other wings of the facility that are short staffed, an authority the Board has held is in and of itself insufficient to establish supervisory authority. *North Montana Health Care*, 324 NLRB 752 (1997), affd. in relevant part, 178 F.3d 133 (9th Cir. 1999).

In conclusion, the Respondent has failed to meet its burden of establishing that the clinical coordinators are statutory supervisors within the meaning of Section 211(c) of the Act or its concomitant burden of showing sufficiently changed circumstances that would justify a finding on the issue contrary to the Board's Order underlying this proceeding.

V. Conclusions Regarding Clark and Hurst

It follows from the above that the Respondent in July 2000 erroneously conditioned its offers of promotion to Clark and Hurst on their acceptance of the Respondent's position that they would become statutory supervisors ineligible to continue to be involved in activities on behalf of the Union. Accordingly, the offers, requiring Clark and Hurst to cease their union activities, were not bona fide. See *Romal Iron Works Corp.*, 285 NLRB 1178 at fn. 1 (1987). I find, therefore, that the offers made to them were invalid, that new and unconditional offers need to be made, and that backpay has continued to accrue since July 2000. See *Central Cartridge, Inc.*, 236 NLRB 1232 (1978). In light of this conclusion, I need not address the General Counsel's contention[22] that in July 2000, the Respondent employed charge nurses and patient care leaders whom it did not consider supervisors.

Providing Names and Addresses to the Union

I. Facts

Judge West found that the seriousness of the Respondent's ULPs warranted not only a broad cease-and-desist order but also a *Gissel* [23] bargaining order. The Board deemed the Respondent's ULPs to be "numerous, pervasive, and outrageous" (at p. 6). It agreed that a

[22] GC's posthearing br. at pp 29 -30.

[23] *NLRB v. Gissel Packing Co.*, 395 U.S. 575 (1969).

broad cease-and-desist order was proper but determined that because of an almost complete turnover in supervisors and management and the substantial length of time that had elapsed since the election in March 1994, a bargaining order might not be enforced by a court of appeals. However, the Board stated (at p. 5):

> Although a *Gissel* remedy is not being imposed, we do find that certain extraordinary remedies are warranted. The Respondent engaged in extensive and serious unfair labor practices when faced with the union organizing effort among its employees . . . [W]e find that special remedies are necessary to dissipate as much as possible the lingering effects of the Respondent's unfair labor practices, and to ensure that a fair election can be held. . . . (footnote omitted)

Accordingly, the Board (at p. 6) ordered, inter alia, that the Respondent "supply the Union, on its request made within l year of the date of this Decision and Order, the names and addresses of its current unit employees." The Board further directed (at p. 8) that a second election be conducted at time, "whenever the Regional Director deems appropriate."

The Union made requests for names and addresses by letters dated July 7, September 11, and October 20, 2000, to which the Respondent responded with the requested information.[24] It was stipulated that the Union made additional requests by letter in March, May, and June 2001, to which the Respondent also responded with information. The Union made a final request by letter dated December 20, 2001.[25] Tillow testified that the Union still needed such a list because the Union's ability to organize and proceed further was impeded by the Respondent's further ULPs. This time, the information was denied, in the form of a letter dated December 26, 2001, from attorney Potts,[26] who stated, "The one year period referenced in Item 2(g) of the Order having long since expired, Norton Healthcare, Inc. is under no obligation to provide you with the requested information."

In her testimony, Tillow referenced three ULP cases involving direct conduct by the Respondent, as opposed to conduct of its predecessor employer, Columbia, which gave rise to this compliance hearing. The General Counsel and the Union contend that because of the ULPs committed by the Respondent herein and unremedied ULPs it has committed in other cases, the Regional Director has not yet scheduled a second election, and in these circumstances the 1-year period should be extended.[27]

I will summarize the other cases here. In the first, the Board, on September 30, 2002,[28] upheld Judge Irwin Socoloff's findings that the Respondent had violated the Act by:

1) Refusing to employ an employee in a CNA position between August 1999 and mid-September 2000, because of her protected concerted activities.
2) Telling Hurst in July 2000 that discussions regarding the Union were prohibited during worktime, while other nonwork discussions were permitted.
3) Coercively interrogating an RN in August 2000.

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[24] See GC Exhs. 10 -14. The Respondent provided separate lists for RNs and clinical coordinators.

[25] GC Exh. 15.

[26] R. Exh. 3.

[27] See GC's posthearing br. at p. 31 fn. 5; Union's posthearing br. at pp. 4 -5.

[28] 338 NLRB No. 34, 2002 WL 3186359.

In the second case,[29] Judge Leonard Wagman found on May 5, 2000, that the Respondent violated section 8(a)(1) of the Act by issuing a warning to an RN on February 25, 1999, because of her protected concerted activities, and by, inter alia, promulgating and implementing a stricter solicitation policy in May 1999. No exceptions were filed, and it became a final Board order on June 16, 2000.

Subsequent to the hearing in this matter, on December 19, 2002, Judge Arthur Amchan issued a decision[30] in the third case Tillow referenced. He found that the Respondent violated Section 8(a)(3) and (1) of the Act by terminating an RN on July 12, 1999, and reporting her to the state board of nursing on July 13, 1999, because of her activities on behalf of the Union. The Respondent and the General Counsel filed Exceptions to the decision.

For reasons stated below, I find that the Respondent remains under a further, but qualified, obligation to furnish names and addresses to the Union

II. Analysis and Conclusions

The Union argues that the language in the Order to "supply the Union, on request made within 1 year of the date of this Decision and Order," the names and addresses of its current unit employees, should be interpreted to mean that the first request needed to be made within 1 year but that the Board intended there be no ending date.[31] I decline to look behind the express language used by the Board and to expand its stated remedy by implication.

It is not my prerogative to dictate to the Regional Director when to conduct a rerun election or to determine how further ULPs found to have been committed by the Respondent should bear on his decision. From the terms of the Order, I conclude that the Board anticipated that the Regional Director would reschedule an election within a period of more or less 1 year. I must also conclude that the Board did not assume that the Respondent would engage in further ULPs.

The Board did not specify a fixed number of requests that would be encompassed by its order to provide names and addresses on request, and I believe it appropriate to conclude that a rule of reason was intended. Obviously, at a certain point, repeated requests could be determined to be burdensome and a form of harassment, rather than a meaningful effectuation of the Board's Order. Inasmuch as I have no idea of the internal deliberations of the Region Office and their communications with the Union during the 1-year period following the Order, I cannot make a conclusions as to the appropriateness of the number of requests the Union made during that period.

Certainly, however, the Respondent's obligation to provide additional lists as per the Order cannot be deemed to continue without any limitation pending an unscheduled rerun election that may be years away, depending on when the General Counsel concludes that all of the Respondent's ULPs have been remedied. In this regard, the Order provided the Union with additional means of information and access to unit employees, to offset the Respondent's interference in the election, so that a fair re-run election could be held in more or less 1 year's time.

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[29] JD-56-00, 2000 WL 33664167.

[30] JD-135-02, 2002 WL 318635939.

[31] See Union's posthearing br. at p. 4.

I do find warranted an extension of the 1-year period for furnishing names and addresses. The Board found the ULPs committed by the Respondent's predecessor to be egregious in nature, and the Regional Director has delayed holding a second election because of the Respondent's commission of further ULPs; significantly, some of them were committed even after the date of the Board's Order in the instant matter.

Nevertheless, I am not persuaded that this extension should be unqualified insofar as the number of requests the Respondent must satisfy. Inasmuch as the provision in the Order was in preparation for a second election, and the date (even the year) of such election is completely indeterminate at this point, I believe fairness demands that the Respondent's obligation to furnish the names and addresses be limited to some extent, to avoid the Union's requests being unduly burdensome to the Respondent while at the same time failing to serve the purpose of the Board's special remedy to ensure a fair re-run election. Depending on when the election is ultimately scheduled and held, providing lists of names and addresses in the interim period could be merely a hollow gesture rather than a meaningful effectuation of the Boards' Order. In balancing these competing considerations, there are no set guidelines to use in arriving at a reasonable numerical limitation. Limiting the Union to one request a year would appear overly restrictive. On the other hand, several requests a year would seem excessive. Accordingly, I believe that a reasonable approach is to order the Respondent to continue to comply with Union requests for names and addresses but to provide for a limitation of one request every 6 months, until such time as a new election is directed or the petition for an election is withdrawn.

On these findings of fact and conclusions of law and on the entire record, I issue the following recommended[32]

ORDER [33]

IT IS HEREBY ORDERED that Respondent Norton Healthcare, Inc. d/b/a Norton Audubon Hospital and Norton Suburban Hospital, Successor to Audubon Regional Medical Center, its officers, agents, successors, and assigns, shall pay the following individuals the indicated amounts of total gross backpay and other reimbursable sums for the period from the third quarter of 2000 through the first quarter of 2002,[34] with interest as prescribed in *New Horizons for the Retarded*, 283 NLRB 1173 (1987), accrued to the date of payment and minus

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[32] If no exceptions are filed as provided by Sec. 102.46 of the Board's Rules and Regulations, the findings, conclusions, and recommended Order shall, as provided in Sec. 102.48 of the Rules, be adopted by the Board and all objections to them shall be deemed waived for all purposes.

[33] The following corrections are hereby made to the transcript.
Tr. 43, L 21 – change "1993" to "1963."
Tr. 47, L 10 – change "cost" to "costly" and add "not cost" before "effective."
Tr. 79, L. 24 – change "stationary" to "stationery."
Tr. 97, L. 14 – change "2000" to "2001."
Tr. 398, L. 5, - change "supervisor's" to "employee's."
Tr. 407, L. 20 – change "89" to "80 to 90."
Tr. 458, L. 22 – change "over-road" to "overrode."
Tr. 480, et seq. – change "Mr. Porter" to Mr. Potts."

[34] I adopt and incorporate by reference the amounts set forth in GC Exhs. 2 -4, attached as Appendix A, which amounts were not disputed by the Respondent, as well as the unreimbursed mileage expenses for Sandusky contained in GC Exh. 8, attached as Appendix B.

tax withholding required by law.

JoAnn Sandusky – $26,226.15, plus pension contributions of 279.72 and unreimbursed mileage expenses of $43.84.
Patricia Clark – $2,339.51, plus pension contributions of $111.96.
Martha Ann Hurst – $3,247.20, plus pension contributions of $162.39.

IT IS FURTHER ORDERED that the Respondent shall take the following affirmative action:

1. Offer JoAnn Sandusky immediate employment at Norton Audubon Hospital or Norton Suburban Hospital as a medical/surgical nurse or other RN position which is substantially equivalent to her former position as lactation consultant, which no longer exists, and make her whole for all losses she may suffer after the backpay periods contained in Appendix A, until such time as the Respondent makes her a valid offer of reinstatement as ordered by the Board.

2. Offer Patricia Clark and Martha Ann Hurst immediate employment as clinical coordinators and make them whole for all losses they may suffer after the backpay periods contained in Appendix A, until such time as the Respondent makes them valid offers of promotion as ordered by the Board.

3. Provide the Union on request, not to exceed once every 6 months until the Regional Director directs a second election or the petition for an election is withdrawn, the names and addresses of unit employees, based on the Board's Order.

Dated, Washington, D.C. March 14, 2003

IRA SANDRON
Administrative Law Judge